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Dietary Dilemmas: Exploring Common Pitfalls of a Low FODMAP Regimen

Dr. Nandi:
Welcome to *GI Insights* on ReachMD. I'm Dr. Neil Nandi. Low FODMAP, you've heard of it, you know it, you recommend it to patients with IBS. While GI clinicians have become better skilled at screening for FODMAP sensitivities and suggesting patients what foods to avoid, we are most definitely not trained, nor do we do a good job, at telling patients what they can eat. On this episode, Kate Scarlata, registered dietitian with over 30+ years of experience and a New York Times best-selling author, will help us understand what are the most common pitfalls of a low FODMAP regimen, and we'll also learn some practical and high-yield FODMAP pearls to share and apply to your patients tomorrow. Welcome to *GI Insights*, Kate.

Ms. Scarlata:
It's fabulous to be here. Thank you for having me.

Dr. Nandi:
We're excited. I know you're a wealth of knowledge, so I'm dying to pick your brain. First off, just to level the playing field for our audience, can you please provide our audience a brief synopsis of what FODMAPs are, and the different phases of implementing a low FODMAP regimen?

Ms. Scarlata:
Absolutely. So FODMAPs are a certain group of small carbohydrates that are commonly malabsorbed, and they've been shown to trigger GI distress, particularly abdominal pain and bloating in individuals with irritable bowel syndrome. The term FODMAPs is an acronym, and it stands for fermentable, creating gas, and then different types of carbohydrates, oligosaccharides, disaccharides, monosaccharides, and polyols. And FODMAPs are really found, these carbohydrates are found in many everyday foods, milk, wheat products, apples, garlic, onion, beans, and even watermelon. The low FODMAP diet itself is a three-phase intervention, so it's really utilized to help the patient quell, calm their symptoms, but also identify what FODMAPs may be triggering their GI distress. So the first phase is an elimination phase. This usually runs anywhere from two to six weeks, and we eliminate all high FODMAP foods from the patient's diet. This is followed by the reintroduction phase, which is really done to identify the person's personal triggers, and it's done over a six-to-eight-week period, where you're systematically adding back FODMAP subtypes, such as fructans and lactose and onion and different types of FODMAPs back into the diet, to really systematically determine which foods are triggering their symptoms. And then the last phase is the personalization phase, and the goal here is to expand the individual's diet to include all the FODMAPs that do not trigger symptoms for their GI symptoms. So we can really liberalize their diet, and include, much more nutrition and more joyful eating.

I would say some of the pitfalls here is that, you know, patients feel so well on the first phase of the diet, that often it can be a little bit require a little coaxing to get them to do the reintroduction phase. But I do find in clinical practice, if you're really up front from the very beginning, that this is a three-phase intervention, and they have to go through all three phases, they're much more amenable and you kind of manage their expectations.

Dr. Nandi:
Yeah, that's really helpful. And I think you're right, you know, one of the pitfalls, they feel so good and they may be over-restricting for a long time, and get weight loss and malnutrition, which we don't want them to do. Now, Kate, Let's say that I'm in the clinic, right? And I have a patient who has bloat distention, relieved with the passage of gas or a bowel movement. I'm suspecting IBS. And while I'm doing whatever workup and testing that I want to do, I want to get the patient moving. I want to get them engaged with the FODMAP regimen. First, though, what are the high-yield foods? What's your checklist for screening a patient to see if they have some FODMAP

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sensitivities?

Ms. Scarlata:
So, typically, you know, in clinical practice, a dietitian would do a food frequency, where we're really looking overall. Like, what are some typical things that they consume over the course of a week? And then we'll do either a 24-hour recall or one-to-three-day food records prior to their visit, where we can really take a peek and see, you know, are they actually consuming FODMAPs, because if they're not eating FODMAPs, then why do a low FODMAP diet? They're symptomatic without them. So some of the common FODMAPs that we see in patients' diets would be granola bars with chicory root extract, or even granola. So a lot of products manufacturers are adding chicory root extract, which is a fructan and highly fermentable, so that's a common trigger. Additionally onion and garlic tend to be very common triggers in our IBS patients. And then wheat in high amounts, so maybe a couple saltine crackers would not be problematic for an individual, but if they were eating a row of Ritz crackers, they might have some triggering of symptoms. And milk is also an additional one, so if they tend to be heavy milk drinkers in large quantity, that can be a common trigger in our patients. And then, less likely, sort of, you have to dig a little bit, some patients are really into smoothies, and they're putting so many types of fruits, it just ends up being too much of a fructose load for their gut, or they're adding sweeteners that they think are healthier, such as agave syrup, which is a source of excess fructose as well, and this can really cause that osmotic effect. Fructose is the smallest of the FODMAPs so it can really draw the water into the intestine and stretch it, causing luminal distention and cramping. And then, sometimes you'll see the patient's overall diet is pretty healthy, fairly low FODMAP, but then they are really dining out and having large quantities of sort of a plethora of different types of FODMAPs.

So it's just too much of a FODMAP load at one time, from many different sources that can kind of trigger their symptoms as well.

Dr. Nandi:
You know, Kate, this is fascinating, and this is exactly why I think more of us need to be employing and working with a dietitian, hand-in-hand, to try to get to the root of these causes, because I can tell you, in a regular clinic visit, it's very challenging to do an in-depth nutrition dive. Not only am I not formally trained in that, right? But, I just do not have the time in clinic to do that, and I think, you know, having a dietitian is critical.

Ms. Scarlata:
Absolutely. And I would say, you know, when you have someone that is an expert in the low FODMAP diet, it's like, you know, a beacon of light, every food you see, you're very trained to identify those, kind of even hidden sources of FODMAPs in different foods as well. So a dietitian with knowledge in the low FODMAP diet can really be such a great resource.

Dr. Nandi:
A great boon, indeed. So Kate, when we implement low FODMAP in the management of our IBS patients, what do the studies show? What is the approximal overall efficacy?

Ms. Scarlata:
So the efficacy range is from 50 to 86 percent. There's a lot of heterogeneity between studies. They're all done a little bit differently. In one study that was a feeding study, they found efficacy at about 70 percent, so I would say, you know, it's somewhere in that 50 to 86 percent. And again, notable reduction in abdominal pain and bloating are really the two endpoints that seem to be get the most benefit from the diet.

Dr. Nandi:
That's phenomenal, right? Because when we think about a lot of our drug studies, we wish that some of our drugs had that kind of efficacy. We wish it beat the 50 percent mark at all. So, 50 to 80 percent - that range is just phenomenal.

Ms. Scarlata:
Absolutely.

Dr. Nandi:
For those just tuning in, you're listening to GI Insights on ReachMD. I'm speaking with Kata Scarlata, registered dietitian and New York Times best-selling author, about the low FODMAP regimen for our IBS patients.

Now Kate, we've been reviewing that dietitians are absolutely invaluable for helping patients manage their diets and their sensitivities. Dietitians are necessary and yet underutilized. And we need them because they can not only gain the insights that a physician or other health professional cannot, but they can also recommend to patients how to substitute or find solutions that fit their diet. You talked about personalization. Kate, can you provide some tips that you provide to your patients for sensitivities such as like onions?

Ms. Scarlata:

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Absolutely. So, when patients are particularly sensitive to onion, and we determine that through the three-phase low FODMAP approach, we would just recommend other wonderful onion flavors that do not have FODMAPs, and some perfect examples of that would be the scallion greens, leek greens. The fructans in onions are in the bulb. So if you have the green, leafy part of that plant, they will be devoid of FODMAPs. So, leek greens, scallion greens. Shallot-infused oil is another example. So because FODMAPs are water soluble, you can take shallot and then just an oil, sauté, get the beautiful flavor of the shallot, and then remove the flesh from the oil and then use that oil to flavor a beautiful onion flavor to whatever dish you're using. So you absolutely do not have to do without onion flavor, there's just little tricks and tools to do that.

Dr. Nandi:
See, these are easy, simple tips I had no idea that you could do, but that's something easy to tell a patient, something powerful, so they get the flavor they want from their food rather than living a flavorless life, shall we say. How about honey? What do we do about honey?

Ms. Scarlata:
It's important to know that honey does have FODMAPs. It's a source of excess fructose, but it's in a quantity greater than a teaspoon, so if you're just using a small drizzle on something, you can go with the honey. It will be in a quantity that is not over pushing the excess fructose into a criteria where it would now be a high FODMAP food. So a teaspoon or less of honey is okay. Otherwise, a great substitute is pure maple syrup, which here in New England we have plenty of. And it imparts beautiful flavor and does not have that excess fructose.

Dr. Nandi:
And one of my favorite foods are broccoli and cauliflower, our cruciferous vegetables. That's one of my favorite words, cruciferous. That seems to be a trigger for many patients. Are there any good substitutes?

Ms. Scarlata:
So, a couple of tips. Again, FODMAPs are very portion size driven, and different parts of the plant have different types of FODMAPs. So, the broccoli floret, you can have up to three-quarters of a cup during the elimination phase in a meal. So I always encourage florets, like as part of a stir-fry, for instance. Cauliflower is pretty high in FODMAPs and the polyols, so we would pull those out. But there's a number of foods that actually have no detectable FODMAPs. Some examples would be carrots, red bell pepper, parsnips, arugula. So there's lots of FODMAPs that no detectable FODMAPs, and in those examples, we would say, you know, go chow them as much as you can. Strawberries have no detectable FODMAPs, for instance. So spinach and chard and arugula tend to all be very low. Radishes have no detectable FODMAPs. Cucumbers have no detectable FODMAPs, so we can kind of play around with the different types of foods and substitute in with better tolerance in our sensitive patients.

Dr. Nandi:
So what I'm learning from you here, just listening these last few minutes, Kate, is that different parts of the vegetable have different concentrations of the FODMAP. And it's not about complete elimination, right? Or complete substitution? It might be, again, it's very much about portion control or quantity. How about pastas and grains that are, especially those that are wheat based, or that have a high fructan content? What do we tell our patients in terms of fructan management?

Ms. Scarlata:
Exactly. So, you know, one of the things that we've learned, and it's a little bit of a trial and error, and that is that sourdough wheat bread, because if it's slow leavened the yeast used in the sourdough culture reduces the fructans. They have different types of digestive enzymes in the yeast and they actually reduce the fructans, so many patients can do slow-leavened sourdough wheat bread, which is lovely and tasty, so that's one option. And then, for other grains outside of the wheat family rice and quinoa and buckwheat are often encouraged. Oats are allowed as well, I encourage oat flour often as a substitute in baking, or there's a variety of gluten free flour blends that work really nicely in baking that individuals can substitute for the wheat grain, which I think is probably the hardest to modify or restrict, just because wheat is a big source of fructans in the American diet. So that, I think, is probably the most sort of challenging food to avoid.

Dr. Nandi:
Okay, I am just soaking up these clinical pearls of wisdom that you are dropping right now. I'm learning a lot from you and I have a lot more to learn, and I'm quite certain that we're going to find that many GI clinicians, of all sorts have a lot more to learn about FODMAP, and need to work with a dietitian. You can learn more from Kate herself at katescarlata.com. Kate, I want to thank you for making the time and sharing your GI insights on our program today. Before we close, do you have any last parting thoughts?

Ms. Scarlata:
My last parting thought is just remember that individuals with IBS really require a personalized dietary approach. We don't want to always assume that the low FODMAP diet is step one. Clean up the patient's diet, make sure they're eating balanced meals, and

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healthy foods, and not skipping meals, and not having, you know, exorbitant amounts of junk food. That can be first step. Adding psyllium husk could be first step. And just to be careful that, you know, because they're seeing an increased risk of disordered eating in our GI patients, that we don't put patients that are at risk on an elimination diet. It's important that we approach these patients really personally, and individually. It is not a one-size-fits-all approach to managing nutrition in our IBS patients.

Dr. Nandi:
Absolutely. Dietitians are critical to executing a low FODMAP regimen, and honestly, critical to managing many digestive health conditions. Kate, thank you so much. For ReachMD, I'm Dr. Neil Nandi. To access this episode and others from *GI Insights*, please visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening.

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